Hospital Letterhead

Hospital ABN 7.

_____
Date of Notice

_____ _____
Name of Patient Admission Date

_____ _____
Address Health Insurance Claim (HIC) Number

_____ _____
City, State, Zip Code Attending Physician's Name

YOUR IMMEDIATE ATTENTION IS REQUIRED

Dear _____: (*Insert the name of the addressee.*)

This notice is to inform you that we have reviewed the medical services you have received for *(specify services or condition)* from *(date of admission)* through *(date of last day reviewed)* and has determined that acute care services are not necessary. This determination is based upon our understanding and interpretation of available Medicare coverage policies and guidelines.

The *(name of QIO)* is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of *(name of State)*. The *(name of QIO)* has concurred with our decision that beginning *(specify date of first noncovered acute care day)* you no longer require an acute level of care. You will begin to receive the type of hospital services which are rendered in a skilled nursing facility (SNF) beginning *(specify date of first SNF swing-bed day)*. This is known as SNF swing-bed services. The Medicare program will pay for your SNF swing-bed services (if you have not used up all your SNF benefit days (100) in the benefit period).

- **If you disagree with this decision and want an expedited reconsideration:**

You may request **by telephone or in writing** an expedited reconsideration of the QIO's determination. An expedited reconsideration will be performed if you make your request while in the hospital. You should make this request immediately through us, or to the QIO at the address listed below.

- **If you do not request an expedited reconsideration:**

You may still request a reconsideration. Instructions on how to request this reconsideration will be given to you in a notice sent by *(name of QIO)*.

- **QIO Reconsideration Results:**

The QIO will send to you a formal reconsideration determination of the medical necessity and appropriateness of your hospitalization and will inform you of your appeal rights.

IF THE QIO OVERTURNS ITS DECISION (i.e., it determines that you require acute care), you will be refunded any amount collected except for any applicable amounts for deductible, coinsurance, and convenience services or items normally not covered by Medicare.

IF THE QIO UPHOLDS ITS DECISION (i.e., it reaffirms that you do not require acute care), you will continue to receive SNF swing-bed services paid under Medicare. You will be responsible for payment of any applicable deductible, coinsurance, and convenience services or items normally not covered by Medicare.

- **QIO Address:**
  (QIO Name)
  (Address)
  (Telephone Number)

Sincerely,

_____

(*Title, e.g., Chairperson of Utilization Review Committee, Medical Staff, etc.*)

ACKNOWLEDGMENT OF RECEIPT OF NOTICE

This is to acknowledge that I received this notice of noncoverage of services from _____*Name of Hospital*_____ at _____*Time*_____ on _____*Date*_____. I understand that my signature below does not indicate that I agree with the notice, only that I have received a copy of the notice.

_____ _____ _____

Signature of patient or authorized representative Time Date

cc: QIO
Attending Physician